CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPI	
		155400	B. WIN	G		03/02/2	:U11
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					AST JACKSON ST		
LIBERTY	VILLAGE			MUNC	IE, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0000	This visit was for	r a Post Survey Revisit	F00	00	Submission of this Plan of		
	[PSR] to the Rec	ertification and State			Correction does not constitute		
	Licensure Survey	y completed on January 6,			admission to or an agreemen with facts alleged on the surv		
	2011.				report.Submission of this Plan		
					Correction does not constitute	e an	
	This visit was in	conjunction with the			admission or an agreement b		
		nt number IN00085755			the provider of the truth of fact alleged or corrections set fort		
	investigated on F	February 8, 2011.			the statement of deficiencies.		
	_				Plan of Correction is prepared		
	Survey dates: M	Tarch 1 and 2, 2011			and submitted because of		
	J	,			requirements under State and Federal law.Please accept the		
	Facility number:	000269			Plan of Correction as our cred		
	Provider number				allegation of compliance.		
	AIM number: 10	00267720					
	Survey team:						
	Ginger McName	e, RN, TC					
	Betty Retherford						
	Karen Lewis, RN						
	Delinda Easterly						
		,					
	Census bed type:	:					
	SNF/NF: 86						
	Total: 86						
	Census payor typ	be:					
	Medicare: 15						
	Medicaid: 65						
	Other: 6						
	Total: 86						
	Sample: 11						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

11FU12

Facility ID:

000269

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	VILLAGE			AST JACKSON ST E, IN47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
		es also reflect state dance with 410 IAC 16.2.			
	Quality review c Cathy Emswiller				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPL	ETED
		155400	B. WING			03/02/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AST JACKSON ST		
LIBERTY	VILLAGE				E, IN47303		
					L, 114-7-000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
F0241		ation, record review and	F02	41	Resident #10 was not		03/11/2011
SS=D	interview the fac	ility failed to ensure			negatively impacted by the alleged deficient practice. LPN	J	
	insulin was admi	nistered in a manner to			#1 has been reeducated on	`	
	ensure resident's dignity was maintained				providing care, including		
	for 1 of 2 residents observed receiving				medication administration, in a	1	
	insulin injections in a total sample of 11.				manner and in an environment	t	
	(Resident #10)				that maintains or enhances ea		
	(Resident #10)				resident's dignity and respect i	n	
	D' 1' ' 1 1				full recognition of their	_	
	Findings include	:			individuality. LPN #1 has beer observed providing care,	1	
					including medication		
	The clinical record for resident #10 was				administration, while maintaini	na	
	reviewed on 3/1/	11 at 1:45 p.m.			resident dignity and respect.2.	~	
					other residents have the poten	itial	
	Resident #10's cu	irrent diagnoses included,			to be affected. The residents		
		ited to, diabetes mellitus,			have been observed and are		
		zheimer's disease.			receiving care, including		
	dementia and Aiz	Elicifici s discase.			medication administration, in a manner and in an environment		
	D 11 . //101 :				that maintains or enhances ea		
		l a current physician's			resident's dignity and respect i		
	· ·	/11, which indicated the			full recognition of their		
	resident was to re	eceive 14 units of			individuality.3. The facility's		
	Novolog insulin	at lunch time.			policies for medication		
					administration and resident		
	During observati	on on 3/1/11 at 11:05			abuse, including		
		ninistered insulin			maintaining dignity and respect have been reviewed and no	τ	
	,	n the abdomen of			changes are indicated at this		
	•	esident #10 was sitting in			time. All nurses and QMA's ha	ave	
		the hall across from the			been reeducated (Attachment		
					A) on medication administratio	n	
		PN #1 instructed the			(Attachment B), including insul		
	•	his shirt so she could			administration, in a manner an		
	administer the in	sulin injection. Resident			an environment that maintains		
	#10 lifted his shi	rt and exposed his lower			enhances each resident's dign and respect. All staff have bee	-	
	abdomen. LPN #	#1 then administered the			reeducated (Attachment C) on		
	insulin injection.	At the time Resident #1			resident abuse (Attachment D)		
	, , , ,				, , ,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/02/2011			
	PROVIDER OR SUPPLIEF	!!	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	lower abdomen of residents were up sitting next to the During an interv Nursing Services she indicated the administer insuli in the resident's for any private ar privacy and dign further indicated have been instru-	iew with the Director of s on 3/2/11 at 8:30 a.m., e nursing staff were to n injections to residents room, in the shower room ea in order to maintain lity for the resident. She the nursing staff should cted related the correct f insulin during the nurses		including resident rights and maintaining dignity and respect in full recognition of residents' individuality. A medication/treatment observation tool has been implemented (Attachment E).4. The Direct Nursing or designee will observe 2 nursing staff, on eashift for a total of 6 observation per day and complete the medication/treatment observation on scheduled work days, providing care for residin a manner and in an environment that maintains of enhances each resident's dig and respect in full recognition their individuality, as follows: Daily for 2 weeks, weekly for weeks, monthly for 2 months, then quarterly thereafter on a ongoing basis for a minimum months. Results of these rew will be discussed at the facilit quarterly QA meetings and the plan adjusted accordingly.5. above corrections were completed on March 11, 2011	cor of ach ons ation ents r nity of 6 iews y's e The		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155400	B. WIN			03/02/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AST JACKSON ST		
LIBERTY	VILLAGE				E, IN47303		
					_,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F0.4				DATE
F0441		ation, interview, and	F04	41	1. Resident #'s 39, 50, 55, 58, 59, and 71 were not negatively		03/11/2011
SS=E	record review, the facility failed to ensure				impacted by the alleged deficie		
	hand hygiene wa	s completed and/or			practice. LPN #'s 1, 3, and 4,		
	completed prope	rly when hand hygiene			QMA #3 have been reeducated		
	was required dur	ing medication and			on infection control, including		
	treatment administration for 2 of 7 nurses				handwashing. Staff have beer		
	and 1 of 1 QMA observed [LPN #'s 1,3,				observed rendering medication		
		and failed to ensure			and/or treatments to ensure hat hygiene was completed proper		
		not come in contact with			when hand hygiene was required		
					during medication and treatme		
		hand sink during a			administration.2. All other		
	treatment for 1 o				residents have the potential to	be	
		esident #'s 58, 59, 71, 39,			affected. Staff have been		
	50, and 55]				observed rendering medication		
					and/or treatments to ensure ha		
	Findings include				hygiene was completed proper when hand hygiene was require	-	
	_				during medication and	eu	
	1 LPN #4 was o	observed on 3/1/11 at			treatment administration.3. Th	ie	
		entered Resident #58 and			facility's policies for infection		
		oom and washed her			control, including handwashing] ,	
					have been reviewed and no		
		her clean wet right hand			changes are indicated at this		
	-	r to dispense the paper			time. All staff have been		
		rned to the medication			reeducated (Attachment C) on infection control (Attachment F		
	cart and licked he	er fingers of her right			including handwashing, in order		
	hand to turn the	pages of the medication			to provide a safe, sanitary, and		
	records [MAR.]	She cleaned the blood			comfortable environment and t		
	sugar meter and				help prevent the development		
	medication cart.	• •			and transmission of disease ar		
		l Resident #58's Ventolin			infection. A medication/treatm	ent	
		medication cart and			observation tool has been		
					implemented (Attachment E).4 The Director of Nursing or	٠.	
		ent's room. She washed			designee will observe 2		
		rned the water faucets off			nursing staff, on each shift for	a l	
	and dispensed the	e paper towel with her			total of 6 observations per day		
	bare wet hands.	She gave Resident #58			and complete the		

000269

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
12.212.11	2. Zoluzellon	155400	A. BUII			03/02/2	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				AST JACKSON ST		
	VILLAGE			MUNCI	E, IN47303		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAU	the inhaler to use medication cart a LPN #4 donned #59's finger and blood sugar. LP' and returned to the chart Resident #5 and draw up the performing hand fingers to turn the LPN #4 cleaned donned gloves and return cart to clean the series and return cart to clean the series dent's diagnous three sident's diagnous three sident's physician's checks three times. The resident #58' reviewed on 3/1/ resident's diagnous and return cart to clean the series dent's diagnous three sident's diagnous and three sident's physician's checks three times. Resident #58' reviewed on 3/1/ resident's diagnous three times.	e and returned to the and replaced the inhaler. gloves, pricked Resident checked Resident #59's N #4 removed her gloves he medication cart to 59's blood sugar result resident's insulin without hygiene. She licked her e pages of the MAR. the blood sugar meter, and checked Resident r. She removed her ned to the medications blood sugar meter. s clinical record was 11 at 11:40 a.m. The ses included, but were abetes mellitus and hysician's orders were 2/28/11. The resident resident are a day before meals. s clinical record was 11 at 2:00 p.m. The ses included, but were aronic obstructive se and diabetes mellitus		IAU	medication/treatment observation tool on scheduled work days, providing care, including medication and treatment administration, in a safe, sanitiand comfortable environment to help prevent the development and transmission of disease an infection, as follows: Daily for weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter on an ongobasis for a minimum of 6 months. Results of these reviewill be discussed at the facility quarterly QA meetings and the plan adjusted accordingly.5. Tabove corrections were completed on March 11, 2011.	ary, and nt nd 2 ping ews 's the	DATE

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T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	B. WING		03/02/2011
PROVIDER OR SUPPLIER		4600 E	ADDRESS, CITY, STATE, ZIP CODE AST JACKSON ST IE, IN47303	1
SUMMARY S (EACH DEFICIENT REGULATORY OR The resident's phrosigned and dated had a physician's checks three time Ventolin inhaler day. 4. On 3/1/11 at at LPN #4 was obsecart. The LPN ling while turning the left the cart, wentand returned with treatment order. completed after ling She washed her ling soiled paper town table. After place bathroom, the LI turned on the sin hands. She wet a placed them on the extending them in the She removed her bathroom and retaresident's shoes.	examination of deficiencies cy must be percepted by full lesc identifying information) rysician's orders were 2/23/11. The resident order for blood sugar es a day before meals and two puffs four times a 11:07 a.m. at 11:07 a.m., erved at the medication cked her fingers twice e pages of the MAR. She to the nurse's station hereigh Resident #71's No hand hygiene was licking her fingers. Hands and placed the els on an over the bed ing the resident in the PN donned gloves and k faucet with gloved two washcloths and he rim of the sink not the bowl of the sink. It gloves, exited the turned with one of the She placed the shoe on	STREET. 4600 E	AST JACKSON ST	(X5) COMPLETION
the resident's righthe resident's room hand hygiene. So cart and gathered resident's treatment.	She placed the shoe on the foot. The LPN exited om without completing the went to the treatment of the supplies for the tent. She placed the over the bed table with the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID:

11FU12

000269

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400			(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2011	
	PROVIDER OR SUPPLIER		STREET A 4600 EA	ADDRESS, CITY, STATE, ZIP CODE AST JACKSON ST E, IN47303	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION DATE
	hand wash and dassisted the reside pants down. She cloths from the son the residents in placed the soiled of the toilet. She completed the treatment was conher bare hands to cloths and place. The LPN rewash the faucet off with Resident #71's clareviewed on 3/1/resident had a 2/telephone order to inner right buttoo cleansed with so ointment was to	els. LPN #4 completed a onned gloves. The LPN lent to stand and pull his e used the wet wash ink to wash the open area right inner buttock. She washcloths on the back e washed her hands and eatment. When the impleted the LPN used opick up the soiled wash them in a plastic bag. It is pick to be a plastic bag. It is a plasti				

000269

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155400	B. WIN			03/02/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AST JACKSON ST		
LIBERTY	VILLAGE				E, IN47303		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0441	5.) The clinical i	record for Resident #55	F04	41	1. Resident #'s 39, 50, 55, 58,		03/11/2011
SS=E	was reviewed on 3/1/11 at 3:25 p.m.				59, and 71 were not negatively		
00 L	Diagnoses for Re	esident #55 included, but			impacted by the alleged deficient practice. LPN #'s 1, 3, and 4, 1		
		to, bipolar disorder and			QMA #3 have been reeducated		
	osteoarthritis.	to, orporar ansoraer and			on infection control, including	u	
	oscour unitis.				handwashing. Staff have beer	า	
	Danin 1	tion on 2/1/11 -+ 2 40			observed rendering medication		
	· ·	vation on 3/1/11 at 2:40			and/or treatments to ensure ha		
	_	tered Resident #55's room			hygiene was completed propei		
	-	dent oral medications fed			when hand hygiene was require		
	to her in applesau	uce and then gave her a			during medication and treatme administration.2. All other	erit	
	drink of water. A	After the medications			residents have the potential to	he	
	were given, LPN	#2 needed to discard the			affected. Staff have been		
	empty medication	n cup and plastic cup into			observed rendering medication	าร	
		o liner was present in the			and/or treatments to ensure ha	and	
		2 obtained a trash can			hygiene was completed proper	-	
		ttom of the trash can and			when hand hygiene was requir	red	
					during medication and		
		y in the trash can. It was			treatment administration.3. The facility's policies for infection	ie	
	_	ch the sides of the trash			control, including handwashing	ı	
	can when the line	er was placed.			have been reviewed and no	,	
					changes are indicated at this		
	LPN #2 then enter	ered the resident's			time. All staff have been		
	bathroom to was	h her hands. LPN #2			reeducated (Attachment C) on		
	pushed down the	lever on the towel			infection control (Attachment F		
	_	r paper towels for use			including handwashing, in order to provide a safe, sanitary, and		
		vere washed. LPN #2			comfortable environment and t		
		hands. After her hands			help prevent the development		
					and transmission of disease ar	nd	
		N #2 obtained the paper			infection. A medication/treatm	ent	
	_	off the water faucet with			observation tool has been		
		owel, and then used the			implemented (Attachment E).4	٠.	
	same paper towe	l to dry her hands.			The Director of Nursing or		
					designee will observe 2 nursing staff, on each shift for	a	
	6.) The clinical i	record for Resident #50			total of 6 observations per day		
	was reviewed on	3/1/11 at 3:10 p.m.			and complete the		
		•					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155400	B. WIN			03/02/2011
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				AST JACKSON ST	
LIBERTY	VILLAGE			1	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
		esident #50 included, but			medication/treatment observation tool on scheduled work	iion
	were not limited to, Alzheimer's dementia				days, providing care, including	,
	with paranoid de	lusions and chronic			medication and treatment	'
	obstructive pulmonary disease.				administration, in a safe, sanit	ary,
					and comfortable environment	
	A 2010 "Tempora	ary Problem List" for			to help prevent the developme	
	resident #50 indicated the resident had				and transmission of disease a	
		ic treatment for urinary			infection, as follows: Daily for weeks, weekly for 2 weeks,	4
	tract infections in				monthly for 2 months, then	
		October of 2010. The list			quarterly thereafter on an ongo	oing
		ident had received			basis for a minimum of 6	
					months. Results of these revie	
		ent for a respiratory			will be discussed at the facility	
	infection in Dece	ember of 2010.			quarterly QA meetings and the plan adjusted accordingly.5.	
					above corrections were	
	_	vation on 3/1/11 at 2:55			completed on March 11, 2011.	.
	p.m., LPN #2 ob	tained a medicated lotion			•	
	from her treatme	nt cart to be applied to				
	Resident #50's le	gs. LPN #2 then entered				
	the resident's roo	m. Without washing her				
	hands or using a	sanitizing gel, LPN #2				
	donned gloves ar	nd pulled the resident's				
		er knee area. LPN #2				
	then massaged th					
	_	egs. LPN #2 removed				
		e gloves and lowered the				
		gs back down over her				
	_	gs back down over her				
	lower legs.					
	LPN #2 then ente	ered the resident's				
		h her hands. LPN #2				
		e lever on the towel				
	*	r paper towels for use				
		vere washed. LPN #2				
	antei nei nands W	TELE WASHEU. LPIN #2				
						l l

l	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDI B. WING			ONSTRUCTION	(X3) DATE COMP 03/02/2	LETED
	PROVIDER OR SUPPLIEF	2	4600 E	ADDRESS, CITY, STATE, ZIP CODI AST JACKSON ST IE, IN47303	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	were washed, LF toweling, turned the clean paper t	hands. After her hands PN #2 obtained the paper off the water faucet with owel, and then used the el to dry her hands.				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155400	B. WING			03/02/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AST JACKSON ST		
LIBERTY	VILLAGE			l	E, IN47303		
					L, 11417 000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	For				DATE
F0441		ecord for Resident #39	F04	41	1. Resident #'s 39, 50, 55, 58, 59, and 71 were not negatively		03/11/2011
SS=E	was reviewed on	3/1/11 at 3:30 p.m.			impacted by the alleged deficie		
					practice. LPN #'s 1, 3, and 4,		
	Resident # 39's c	urrent diagnoses			QMA #3 have been reeducate		
	included, but were not limited to,				on infection control, including		
		bhy and constipation.			handwashing. Staff have been		
	and a significant of the signifi				observed rendering medication		
	Resident #39 had	l a current physician's			and/or treatments to ensure hat hygiene was completed proper		
		/11, which indicated			when hand hygiene was requi		
	· ·	s to receive Miralax (a			during medication and treatme		
		`			administration.2. All other		
		ion) 17 grams in 8 ounces			residents have the potential to	be	
	of liquid daily fo	r constipation.			affected. Staff have been		
					observed rendering medication		
	During observati	on on 3/1/11 at 11:45			and/or treatments to ensure hat hygiene was completed proper		
	a.m., Qualified M	Medication Aide #3			when hand hygiene was requi	-	
	(QMA) administ	ered Miralax medication			during medication and		
	to Resident #39.	During the preparation			treatment administration.3. Th	ne	
	of the Miralax m	ediation, QMA #3			facility's policies for infection		
		ax medication, which is			control, including handwashing] ,	
	_	form, from the original			have been reviewed and no changes are indicated at this		
	_	small plastic drinking cup			time. All staff have been		
		QMA #3 spilled some			reeducated (Attachment C) on		
		edication onto her back			infection control (Attachment F		
					including handwashing, in orde		
		ng the transfer of the			to provide a safe, sanitary, and		
		the original container			comfortable environment and the help prevent the development	10	
	_	cup. QMA #3 used the			and transmission of disease a	nd	
	_	other hand and scrapped			infection. A medication/treatm		
		ication from the back of			observation tool has been		
	her hand into the	drinking cup. QMA #3			implemented (Attachment E).4	.	
	then administered	d the Miralax medication			The Director of Nursing or		
	to the resident.				designee will observe 2 nursing staff, on each shift for	_	
					total of 6 observations per day		
	During an intervi	iew, with the Director of			and complete the		
	<i>5</i>	,			'		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/02/2011		
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
	indicated QMA # the Miralax med onto her hand du the medication. 8. Review of the policy, titled "Ha provided by the a 7:50 a.m. indicat "Policy: To provide prote staff when perfor procedure. To er clean so as to ass clean environme prevention of and disease and infect Procedure: 1. Prepare paper 7. Pat hands dry 8. Turn off fauce	nsure that hands remain sist in maintenance of a nt and assist in the d the transmission of etion. toweling with paper towel. ts with paper towel and mediately in waste		medication/treatment observation tool on scheduled work days, providing care, includin medication and treatment administration, in a safe, saniand comfortable environment to help prevent the developm and transmission of disease a infection, as follows: Daily foweeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter on an one basis for a minimum of 6 months. Results of these rewill be discussed at the facilit quarterly QA meetings and the plan adjusted accordingly.5. above corrections were completed on March 11, 2011	g tary, and ent and r 2 going iews y's e The	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/02/2011	
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
		ands must be washed:				
	2. Before and after direct resident contact"					
	facility failed to	was cited on 1-6-11. The implement a systemic ns to prevent recurrence.				
	3.1-18(i)					

	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY	
OF CORRECTION		A. BUILDING		COMPLETED	
155400		B. WING		03/02/2011	
PROVIDER OR SUPPLIER					
VILLAGE		MUNCIE, IN47303			
SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(EACH DEFICIENCY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIA		
REGULATORY OR	LSC IDENTIFYING INFORMATION)	 		DATE	
		F0441	59, and 71 were not negatively impacted by the alleged defici practice. LPN #'s 1, 3, and 4, QMA #3 have been reeducate on infection control, including handwashing. Staff have bee observed rendering medicatio and/or treatments to ensure hygiene was completed prope when hand hygiene was requi during medication and treatments administration. 2. All other residents have the potential to affected. Staff have been observed rendering medication and/or treatments to ensure hygiene was completed prope when hand hygiene was requi during medication and treatment administration. 3. The facility's policies for infection control, including handwashing have been reviewed and no	ent and d n ns and rly red ent be ns and rly red ent be ns and rly red	
			time. All staff have been reeducated (Attachment C) or infection control (Attachment F	=),	
			to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of disease a infection. A medication/treatm observation tool has been implemented (Attachment E).4 The Director of Nursing or designee will observe 2 nursing staff, on each shift for	d tto nd nent 4.	
	OF CORRECTION PROVIDER OR SUPPLIER VILLAGE SUMMARY S (EACH DEFICIEN	OF CORRECTION IDENTIFICATION NUMBER: 155400 PROVIDER OR SUPPLIER VILLAGE SUMMARY STATEMENT OF DEFICIENCIES	OF CORRECTION IDENTIFICATION NUMBER: 155400 ROVIDER OR SUPPLIER VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING 460 MU PREFI FREGULATORY OR LSC IDENTIFYING INFORMATION)	DEFORECTION IDENTIFICATION NUMBER: 155400	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 03/02/2011	
NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	MUST BE PERCEDED BY FULL PREFIX CROSS-REFEI CROSS-REFEI		AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) CX5) COMPLETION DATE	
				medication/treatment obsettool on scheduled work days, providing care, include medication and treatment administration, in a safe, sa and comfortable environment to help prevent the develop and transmission of disease infection, as follows: Daily weeks, weekly for 2 weeks monthly for 2 months, then quarterly thereafter on an obasis for a minimum of 6 months. Results of these rewill be discussed at the fact quarterly QA meetings and plan adjusted accordingly. Sabove corrections were completed on March 11, 20	evation ling anitary, ent and ment e and for 2 angoing eviews lility's the i. The	